

# **FIRST YEAR ANNUAL REPORT**

**October 1, 2002 through September 30, 2003**

***Providing Child Survival Services to Rural and Peri-Urban Populations in Bolivia***

**(Cooperative Agreement No. HFP-A-00-02-00035-00)**

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## **A. Main Accomplishments of the Program**

The Child Survival 18 program, Providing Child Survival Services to Rural and Peri-urban Populations in Bolivia, established its indicator baseline in December of 2002 and January of 2003, within the two beneficiary regions of El Alto and Montero. The baseline was developed through both qualitative methods (focus groups) and quantitative studies (Knowledge, Practice, Coverage surveys).

During Year One, Consejo de Salud Rural Andino (CSRA) began an in-depth review of the program's methodology (Census-Based, Impact-Oriented approach) in order to ensure effective program delivery in the project sites. As a result, newly improved training activities were implemented that focused on the program's health personnel and community volunteers within the El Alto region. Participants included CSRA health personnel, Ministry of Health personnel involved in the project, and community health volunteers. In addition, CSRA has produced an updated training manual on CBIO in order to provide a greater explanation to personnel and volunteers about the methodology's instruments and strategies.

One of the key accomplishments of Year One has involved the program's focus on IMCI. Several training workshops were conducted this year in order to coordinate activities and develop strategic follow up teams at the CSRA central office. CSRA was subsequently assigned to lead the Departmental Committee for IMCI for the Bolivian association of child health, PROCOSI, as a result of CSRA's heavy focus on IMCI strategies. During the third quarter, 100% of the health personnel were trained in both El Alto and Montero in the IMCI Strategy and its clinical components. The Bolivian Ministry of Health selected a CSRA staff member to participate in and facilitate the MOH's community IMCI trainings. This leadership role has resulted in new visual aids for the project's promoters and health volunteers. Additional follow up tools and activity records for personnel have also been distributed. The new role has also enabled CSRA to leverage the CS-18 program in order to promote IMCI strategies among fellow NGOs working in nearby communities. For example, CRECER, a micro-credit non-profit who has worked with CSRA on a USAID funded Matching Grant, has begun participating in IMCI trainings. CSRA has also begun related activities to encourage the 16 healthy practices. Presently, tools are being developed jointly with the Ministry of Health to facilitate these activities.

Quality Assurance checklists were developed in Year One in order to begin achieving the program's objective of strengthening the IMCI operational capacity of health personnel (in terms of detection, classification, treatment, orientation and follow-up activities). Montero, specifically in the Villa Cochabamba region, integrated the Quality Assurance strategies into their activities. As a result, substantial improvements were made in the quality of the collected data used for the baseline. Of the 15 indicators, 80% of them have compliance greater than 80%. At the same time, seven indicators have been significantly improved (from 0% to 100%) in their compliance.

As part of the Behavior Change Communication (BCC) strategy, CSRA implemented barrier analysis training workshops. Key personnel from the CSRA central office, El Alto staff, and Montero staff participated in these workshops. As a result, implementation teams from each project site have been developed to prioritize their respective interventions according to the baseline results. Training activities for health personnel and volunteers were developed directly related to BCC including themes on self-esteem, communication, and negotiation skills.

In El Alto, the project has seen an overwhelmingly positive response in the recruitment of community health workers. At the start of Year 1, the program recruited almost 15 volunteers, but by the end of

Year One, the program was able to recruit 36 volunteers thanks to key negotiations with community leaders and promotion within neighborhood associations and the municipal government. CSRA has carried out two centralized training workshops for these volunteers with themes including the CBIO methodology, self-esteem, communication skills, and negotiation related to home visits. It should be recognized that these themes are very important particularly since the majority of these volunteers are new to CSRA and the program.

In Montero, the work plan with community health volunteers has been modified to include a more aggressive work incentive policy in order to increase volunteer retention. These incentives are primarily aimed at activities related to the key indicators of the project. The new incentive based program was designed with the intention to considerably increase the number of volunteers in each of the three sectors of the project in Montero. Presently, there are 35 volunteers.

At the conclusion of Year One, an analysis of the relation between recurring costs and the generation of local funds has shown that the recovery percentage reaches an average of 45% within all project areas. When analyzed by geographic area, El Alto totals 35% and Montero 47%. These results, considering the goals set for the end of the project, can be considered as very positive accomplishments for this first year.

In accordance with CSRA's institutional strategy as administrators of regional health services, the signing of an agreement for shared management with El Alto's municipal government and other key stakeholders was a major accomplishment in July of 2003. The agreement delegates the management of El Alto's Senkata 79 health post to CSRA and the provision of health services in the respective geographic area. The sector of Senkata contains approximately 25 neighborhoods and 13,200 inhabitants. The fulfillment of obligations within this Agreement will be evaluated during the first months of Year Two, and pending on its results, management delegation could potentially be increased to include all of the health posts in El Alto's District 8 (Senkata, Atipiri, and Cumaravi Sectors), bringing the total population close to 35,500 inhabitants. In Montero, there is an even more complex environment due to a great political uncertainty on the stability of health officers at the municipal government and regional Ministry of Health. Towards the conclusion of Year One, CSRA was able to develop a draft agreement with similar characteristics to that of El Alto. This version will be submitted for review by its counterparts in Santiestevan, Montero.

A new institutional officer for co-management began working for the project in May 2003. CSRA's central office has been working with him to finalize the implementation guide for El Alto's Shared Management Model. The finalized version of this guide, in addition to the model's module plan and content will be presented in November 2003 at CSRA headquarters at which time final adjustments will be made. Full implementation of this model in El Alto will be operative by the second quarter of Year Two.

During the last quarter of Year One, CSRA completed the customization of CORE software package to include the services covered by the national insurance plan for mothers and children. A pilot is planned for the first quarter of Year Two that will include a gradual implementation across El Alto and Montero by the second quarter of Year Two.

### **KEY INTERVENTIONS**

- March 2003—health services began in El Alto's Senkata health post.
- Cold Chain consolidation and permanent immunization services began in May 2003.
- Good follow up indicators in diarrhea and dehydration cases detected in children younger than 2 years of age.

- Community group activities implemented in Montero to foster key educational messages on diarrheal disease control through hand washing.
- Good Vitamin A coverage in Montero.
- Coordination with the Municipal Government program called MANITOS aimed at encouraging better nutritional practices in children.
- Establishing a referral system with the CRIN center in El Alto for the rehabilitation of children with severe malnutrition.
- Increasing coverage in prenatal controls in El Alto.
- Good coverage of the 4th prenatal control (related to the new CPN) in Montero.
- Regular educational activities for student population in Montero.
- Very good coverage levels of TT in the feminine population in Montero.
- Group and interpersonal educational activities in IMCI in Montero and El Alto.
- Quality standard implementation in the IMCI implementation.
- Correct IMCI application reaches a score of 85% in the evaluated personnel.
- IMCI quality standard revision meeting in Montero and El Alto.
- Elaboration and implementation of an individual monitoring instrument in the strategy palliation.
- Elaboration of strategy implementation regulations for El Alto and Montero.

### TRAINING ACTIVITIES CARRIED OUT

- CS 18 Project Induction workshops in La Paz and Montero.
- Start-up workshops for key personnel and local representatives on the CS 18 project.
- Initiated training on census-based methodology for health personnel in Montero, El Alto, and for El Alto volunteers.
- Training on barrier analysis for key personnel and operative teams.
- Induction workshops in the IMCI strategy for central office staff and operative teams.
- 100% (26 persons) personnel trained in the clinical component of IMCI.
- Training on the national insurance plan for mothers and children for Montero personnel.
- Training of a CSRA member as Community IMCI facilitator.
- Training on communication and negotiation skills for health personnel and volunteer personnel in El Alto.
- Training workshops for immunization, nutrition, prenatal controls, and reproductive and obstetric risks in Montero.
- Training workshops in Montero for health personnel in Quality Assurance and LQAS methodology.
- Training workshops in Montero for voluntary health personnel in mother/child health including immunizations, pregnancies, and reporting forms.

**Table 1: Progress Towards Technical Objectives**

OBJECTIVES/INDICATORS	Progress on Target?	Comments
Increase the number of children between 12 and 23 months who are fully vaccinated before 13 months of age from 33.3% to 55%	Yes	
Increase the percentage of children under two years of age who receive the same or greater quantities of solid food during an episode of diarrhea during the past two weeks from 45.4%	Yes	

**CURAMERICAS FIRST YEAR CHILD SURVIVAL ANNUAL REPORT--BOLIVIA**

<b>OBJECTIVES/INDICATORS</b>	<b>Progress on Target?</b>	<b>Comments</b>
to 65%		
Increase the percentage of children from 0 to 23 months with diarrhea in the past two weeks who receive ORS from 42% to 65%	Yes	
Increase the percentage of mothers who regularly wash their hands with soap and water at key moments from 4.4% to 30%	No	Although CSRA has conducted training activities in this area, in order for the effect adoption of this skill a clear BCC strategy must first be agreed upon
Increase the percentage of children 0 to 23 months with cough and rapid breathing who receive treatment from a trained health care provider from 37.6% to 48%	Yes	
Decrease the percentage of children 0 to 23 months who are underweight from 8.8% to 5%	No	No promotion activities have been carried out to date that follow the recommendations made in the PROPAN study in El Alto and other studies in Montero.
Increase the percentage of children 12 to 23 months who are immediately breastfed (during the first hour after birth) from 46% to 67%	N/A	This indicator will be measured during the mini-KPC scheduled for 2004.
Increase the percentage of children 6 to 23 months who receive Vitamin A supplements during the last six months from 55.6% to 80%	Yes	
Increase the percentage of mothers of children 0 to 23 months who have received at least one prenatal control during their last pregnancy from 81.6% to 90%	Yes	
Increase the percentage of mothers of children 0 to 23 months who receive at least 2 tetanus toxoid doses during their last pregnancy	N/A	This indicator will be measured during the mini-KPC scheduled for 2004.
Increase the percentage of mothers 20 to 24 years of age who are fully vaccinated with TT (5 doses)	N/A	This indicator cannot yet be reported because the baseline and targets were recently established. The project goal was set at 30%.
Increase the percentage of mothers of children 0 to 23 months who are able to recognize at least 2 newborn danger signs from 7.2% to 40%	N/A	This indicator will be measured during the mini-KPC scheduled for 2004.
Increase the percentage of mothers of children 0 to 23 months who are able to recognize at least 2 danger signs during the postpartum period from 4.2% to 40%	N/A	This indicator will be measured during the mini-KPC scheduled for 2004
Increase the percentage of mothers of children 0 to 23 months who receive Vitamin A after their last pregnancy from 21.4% to 80%	Yes	
Increase the percentage of mothers of children 0 to 23 months who know at least 2 danger signs in their sick child that required treatment from 29/1% to 40.5%	N/A	This indicator will be measured during the mini-KPC scheduled for 2004.
Number of sessions with the health team to review and analyze the results of the IMCI quality standards—5 sessions	Yes	
Increase the percentage of children under 5 years of age who have been evaluated using the IMCI strategy from 0% to 90%	Yes	

<b>OBJECTIVES/INDICATORS</b>	<b>Progress on Target?</b>	<b>Comments</b>
Increase the percentage of health personnel who score at least 90% on the application of Clinical IMCI quality standards from 0% to 90%	Yes	
Increase the percentage of pharmacies in the health posts that have at least 90% of essential medicines in stock necessary for IMCI implementation from 0% to 90%	Yes	

**Table 2: Progress Towards Sustainability Objectives**

<b>OBJECTIVES/INDICATORS</b>	<b>Progress on Target?</b>	<b>Comments</b>
Increase the percentage of recurring costs that are recuperated locally (municipalities, state, sale of services and others) from 40% to 65%	Yes	
Increase the percentage of health personnel (doctors, nurses, auxiliary nurses) who consistently follow IMCI protocols from 0% to 90%	Yes	
Design, develop, and implement a model specific to El Alto for health system operations	Yes	
Adapt accounting software in 100% of the project areas to improve financial management	Yes	

**B. Factors affecting or preventing the achievement of goals and objectives and actions taken by the project when faced with these difficulties.**

- Census activities in the El Alto region were delayed due to the postponement of the health post inauguration in Senkata, El Alto, by the Municipality (April 2003). During this delay, CSRA continued with advertising and awareness activities within the communities. Finally, there is a growing demand for assistance-type services in the health post in Senkata which are currently being unmet by both the Municipality and the MOH due to staff shortages. Mobilization of project staff to the community improved during the last quarter of this first year with the arrival of new personnel from the MOH. With this additional staff, CSRA finished the community census in six neighborhoods. This activity will continue as a priority for the 1<sup>st</sup>, 2<sup>nd</sup> and 4<sup>th</sup> quarters of this second year.
- CSRA had planned to begin implementing the Quality Assurance Program on an institutional level during the first part of Year One. Despite having conducted an induction meeting midway through the first year with key administrative personnel on the methodology characteristics, the QAP was delayed due to the departure of CSRA's Administrative Manager. CSRA is in the process of appointing a new person to the Administrative Manager position. Once the new manager is hired, CSRA will consider this a priority to continue with the implementation of the QAP program.
- Plans to redesign or reformulate the Institutional Supervision System were delayed by political turmoil in some of the key implementation zones. Regrettably, activities in these zones were repeatedly blocked by regular social conflicts (riots and infrastructure delays, including

roadblocks) during Year One. Thus, the development of the Supervision System, along with the definition and design of the BCC strategy, received maximum priority following the crisis. CSRA plans to conclude the Supervision System design (its second phase) by the end of the first quarter of 2004 and immediately proceed to its implementation during the 2<sup>nd</sup> quarter of Year Two. Due to the magnitude of the projects indicators, it will be necessary during the implementation stage to establish a priority group in which to implement the supervision system instruments. The difficulty lies in how to articulate the elements of Quality Methodology within the supervision system in a way that is coherent, consistent and complementary.

- BCC activities were delayed due to time limitations. For example, CSRA continues to wait for the results of the formative study developed by a member of PROCOSI in El Alto. Progress in the design of the strategy has also been slow.
- Due to time limitations, contact between the person in charge of the BCC, key personnel, and Montero has been minimal. Though it was anticipated that the BCC coordinator would participate in the overall evaluation of the First Year of the project, he was only able to participate in the workshops in El Alto due to the social crisis. A coordination and planning activity meeting has been planned for November 2003 to cover the following topics: to gather key information for the BCC strategy design; to do follow-up on the Barrier Analysis methodology implementation; to replicate training activities aimed at Health Volunteers; to carry out several activities on visual aids availability, and to address themes such as co-management of the region.
- A significant delay occurred while recruiting Community Health Volunteers in El Alto due to the delay in opening the Senkata health post. Also, due to a volunteer recruitment program that already existed at the municipal level in El Alto, CSRA had to negotiate with the municipality to avoid duplication of efforts, reach an agreement on training plans, and assign tasks for the community volunteers.
- In Montero, a decrease in activities and care provided by the Health Volunteers has been evident during this first year. Although 35 volunteers were recruited during this first year, the real number of volunteers who are actively working is less. Because of the decrease in retention and participation, the technical personnel in Montero has reviewed its work plan and has included a series of adjustments to the recruitment, training, incentives, and information plans. These new revisions will be implemented during the coming months.
- Throughout much of Year One, there has been a shortage in vaccine supplies provided by the MOH at regional level in El Alto's Senkata health post. The Municipality and the MOH are having problems providing supplies for children older than 12 months of age. Personnel from El Alto has been collecting data on the need for immunization and negotiating at the central level the need for more vaccines in El Alto. This documented claim will be presented to the Regional Director of El Alto in the coming months.
- There are weaknesses in the follow-up process for diarrhea and dehydration cases in Montero and pneumonia in El Alto. Thus, in the evaluation and planning workshops scheduled for the Year Two of the project, we will work to ensure that improved instruments will be used to follow up in these areas.
- The referral system in El Alto for children with malnutrition requires improvements in areas including counter referrals and follow-up after the child leaves the CRIN rehabilitation center.
- Due to the delay in activities in El Alto and the reorganization activities of the Community Health Volunteers in Montero, the training and implementation activities of the IMCI

community component have been delayed in the project's first year. CSRA is working to make up these activities in Year Two

**C. Project areas that require technical assistance**

Although CSRA will continue working on the completion and implementation of the supervision system, additional technical assistance is needed to: a) evaluate the work between the Quality Assurance Methodology and CSRA's supervision plan; b) assistance during the supervision system's implementation phase; and c) the systematization of Quality Assurance for an effective institutionalization.

**D. Description of substantial project changes in from the program description and DIP that will require a modification in the cooperative agreement.**

There have been no substantial changes in the Project to report.

**E. For each of the recommendations made in the DIP, please provide a thorough description of the activities that are being undertaken to implement each one.**

One of the recommendations of the program's approved Detailed Implementation Plan was for a more detailed management plan and supervision system. CSRA subsequently designed interview guides in order to determine a diagnosis on the supervision system at operative and field levels. Annexed to this document is a copy of the institutional proposal for the project's management plan and supervision system, including the timeline and those responsible for each activity.

**F. For projects in their first or second year: If specific information was requested for response during the DIP consultation for this program, please provide the information as requested.**

The DIP revision request was to provide a more detailed project Supervision System proposal. Information in this area is included in Annex A of this report.

Additionally, establishing a baseline for Objective 11's indicator was pending (Percentage of mothers ages 20-24 who are completely vaccinated with five TT doses). The proposed established goal for the project is 30% (Montero, 40%; El Alto, 20%). In regards to the goal for pregnant women with 2 TT doses in their last pregnancy, it has been suggested that information from the mid-term KPC survey be used to establish that goal figure.

**G. Program Management – Factors that positively or negatively affected the overall management of the program.**

**Technical and Financial Areas**

Aside from the advances made in the consolidation of operative teams in El Alto which include accounting and administrative areas as well as progress made in customizing and implementing the CORE software package, the project has benefited through improved central office relations and support to Montero. CSRA's central office has been able to modify its control processes, like monitoring and evaluation, in order to adapt to Montero's needs and program strategies. Some

additional work and improvement needs to be seen in the financial management and reporting consistency between the central office, El Alto and Montero, and Curamericas. For example, during Year One, it was realized that the financial disbursement and administrative schedules for the program did not coordinate with the technical department's schedule of activities. As a result, Year Two's schedules will be reviewed on a quarterly basis rather than yearly.

The program has also greatly benefited from the development of an implementation committee which meets on a monthly basis to analyze technical and institutional activities. The committee consists of El Alto and Montero Directors and CSRA's Operations and Technical Management leaders. In addition, a management committee has been formed to meet periodically to review the program's progress and encourage decision making on a macro-institutional level. This committee consists of managers from CSRA's central office administrative, financial, technical, and operations and human resources departments, and CSRA's National Director.

### **Human Resource Area**

As mentioned earlier, one of the most significant challenges relative to human resources occurred with the unexpected departure of the person in charge of coordinating the census process.

In July 2003, CSRA laid off its Administrative Manager who was responsible for the Quality Assurance program's implementation of administrative processes in the central office. With his departure, the management responsibilities were shifted and carried out by the Financial and Human Resources management team.

In El Alto, the project implementation team was created some time before the opening of the Senkata health post. So once the post opened, personnel began working immediately and without delay. However, the original team of people proved to be too small in comparison to the overwhelming demand by the community for services. Subsequent negotiations with the MOH and the municipal government resulted in additional human resources at the health post. By the end of Year One, the Senkata health post had 16 people on staff (doctors, nurses, nurse's aids, and administrative staff). Nine of these are paid by CSRA, 5 by the MOH, 1 by the municipal government and 1 is considered a shared employee. In Montero, the new health post (CLEM) began operating and providing services during the second quarter of Year One. However, it soon became clear that they, too, require additional personnel. As a result, negotiations are in progress to generate more contributions from local counterparts to support additional staffing needs.

### **Communication System and Team Development.**

The main means of communication in the central office is telephone and email between El Alto and Montero. By the end of Year One, the Senkata health post received internet service. In Montero, only the Villa Cochabamba health post has a phone line and internet service, while the CLEM and Red Cross posts do not.

Unlike previous years, the support provided by the central office to Montero has been more frequent and consistent since the beginning of the project. This support has included visits to establish the baseline, trainings, follow up on the project's key implementation activities, and evaluation and planning workshops.

Communication systems between Curamericas and CSRA were consistent thanks to email and telephone services. Curamericas' program backstop traveled to Bolivia and the program sites three times in Year One to conduct and facilitate trainings and work with key program staff. In the third quarter, Curamericas' Executive Director visited the central office to meet with key personnel and sign a Cooperative Agreement to confirm expectations and responsibilities between CSRA and Curamericas during the CS-18 project.

### **Relations with local partners and other organizations**

Relations with the key figures within the municipal government and El Alto's MOH Regional Director were good in Year One. However, many of these individuals have either been demoted or released as a result of the recent political crisis. As such, it will be increasingly important for CSRA to re-establish a good and productive rapport with these new counterparts during Year Two.

CSRA also coordinated with CRECER to begin activities in El Alto and Montero where CRECER also works. CSRA plans to coordinate some community IMCI activities with CRECER during the first quarter of Year Two.

### **Organizational capacity assessment**

CSRA implemented an organizational assessment in Year One that included management, financial and human resource components. The assessment focused on revising and analyzing of all the processes in the three aforementioned areas and contrasted them to the existing organizational structure. CSRA leveraged those results to modify their current organizational model and is dedicated to developing a detailed description of the processes included. Though there is progress towards improving CSRA's overall organizational capacities, the technical skill set of the organization has yet to be fully assessed. CSRA will work with Curamericas in Years Two and Three to review the Institutional Self Assessment process in order to evaluate its internal skill sets and processes.

## **H. Detailed Work Plan**

**Table 3: Year Two Detailed Work Plan**

<b>Project Year #2</b>		
<b>Activity</b>	<b>Time Frame</b>	<b>Responsible</b>
Conduct censuses in Senkata (total of 25 neighborhoods)—El Alto	October 2003-March 2004	CSRA Regional Director—El Alto
Conduct censuses in Atipiris (total of 21 neighborhoods)—El Alto	June-September 2004	CSRA Regional Director—El Alto
Community information sessions reporting census results in Senkata—El Alto	December 2003 March-April 2004	CSRA Regional Director—El Alto
Census updates—Montero (3 areas)	June-July 2004	Technical Director—Montero
Mortality Analysis Workshop—Montero	September 2004	Technical Director—Montero
CBIO training for community volunteers and health personnel—	December 2003-March 2004 July-August 2004	Regional Technical Staff—Montero and El Alto

**CURAMERICAS FIRST YEAR CHILD SURVIVAL ANNUAL REPORT--BOLIVIA**

<b>Project Year #2</b>		
<b>Activity</b>	<b>Time Frame</b>	<b>Responsible</b>
Montero and El Alto		
One introductory IMCI workshop in El Alto for new personnel	December 2003	IMCI Coordinator
Two refresher courses in Clinical IMCI (one in Montero, one in El Alto)	December 2003 and January 2004	IMCI Coordinator
Initiate Community IMCI trainings for Health Volunteers	January -March 2004	IMCI Coordinator
Implementation of IMCI monitoring and evaluation processes for Health Volunteers	April-June 2004	IMCI Coordinator Technical Director El Alto Technical Director Montero CSRA Regional Director El Alto
Implementation of Quality Assurance program in El Alto	January 2004	CSRA Technical Director Regional Director
Reorganization of key personnel for implementation of Quality Assurance Program, La Paz	October-December 2003	CSRA Technical Team
Implementation of Quality Assurance Program in CSRA Central Office	January 2004	CSRA Technical Team CSRA Administrative Manager
Implementation of Supervision tools in El Alto and Montero	October-December 2003	CSRA Technical Director
Completion of Supervision system design	October-December 2003	CSRA Technical Director
Implementation of supervision system	January 2004	CSRA Technical Director Regional Technical Directors
Completion of BCC strategic design	October-November 2003	BCC Coordinator
Implementation and integration of BCC strategy in IMCI	December 2003	BCC Coordinator CSRA Regional Technical Directors
Development of additional health education materials	November-December 2003 May-June 2004	BCC Coordinator
Training of key CSRA staff in best practice methodology by Curamericas backstop	May 2004	Curamericas CS 18 backstop BCC Coordinator
Implementation of Best Practices methodology in Montero and El Alto	July 2004	BCC Coordinator
Re-launching of new Community Health Volunteers program, Montero	November and December 2004	CSRA Regional Technical Director Regional Director, Montero
Schedule meetings with local counterparts to address current needs	November and December 2003	CSRA Regional Directors CSRA Regional Technical Directors
Conduct mini surveys for key indicators	July-September 2004	CSRA Project Director CSRA Regional Technical Directors
Revise and adjust child registers to assure effective follow-up and referral for children with diarrhea and pneumonia	November-December 2003	CSRA Regional Technical Directors
Incorporate recommendations from the PROPAN study into the planned activities in El Alto	November-December 2003	BCC Coordinator CSRA Regional Director, El Alto
Training session in neonatal IMCI for health workers	November 2003	IMCI Coordinator
TT vaccination campaigns in student population and other organized	March – September 2004	CSRA Regional Directors

<b>Project Year #2</b>		
<b>Activity</b>	<b>Time Frame</b>	<b>Responsible</b>
groups		
Revision and adjustment of patient records of pregnant women to assure effective follow-up on prenatal controls, attention to childbirth and control of puerperal period	November-December, 2003	CSRA Regional Technical Directors
Traning in Childbirth Plan Methodology	January 2004	IMCI Coordinator CSRA Regional Technical Directors
Two training sessions in IMCI for El Alto and Montero	January and February, 2004	IMCI Coordinator
Sing agreement with CRECER for implementation of the IMCI in the communal banks of the El Alto.	November and December, 2003	Project Director Regional Technical Directors
Evaluate Shared Management Agreement La Paz	January 2004	BCC Coordinator Montero Regional Director
Negotiation and singnature of agreement / Montero Management contract	November-December 2003	Project Director
Presentation/preparation of the shared management model for La Paz	November 2004	BCC Coordinator
Implementation of management shared model in La Paz	January 2004	Project Director
Implementation of pilot cost package CORE	November and December 2003	Finance Director
Implementation of cost package to both CSRA geographic health areas.	January 2004	Finance Director

**I. Identification of a new methodology or process that has potential impact on the project. Please attached a summary page where relevant.**

None.

**J. If a topic in these guidelines does no apply to the program, please indicate this in the annual report. If the program has not yet obtained sufficient information to fully describe an element, the please describe plans to obtain this information.**

None.

**K. Include in the yearly report other relevant aspects of the program that may not be covered in these guidelines.**

None.

## ANNEX A: REPORT ON THE DESIGN OF THE SUPERVISION SYSTEM CSXVIII – USAID PROJECT

### Design Stages:

The following steps were taken in the design of the supervision system:

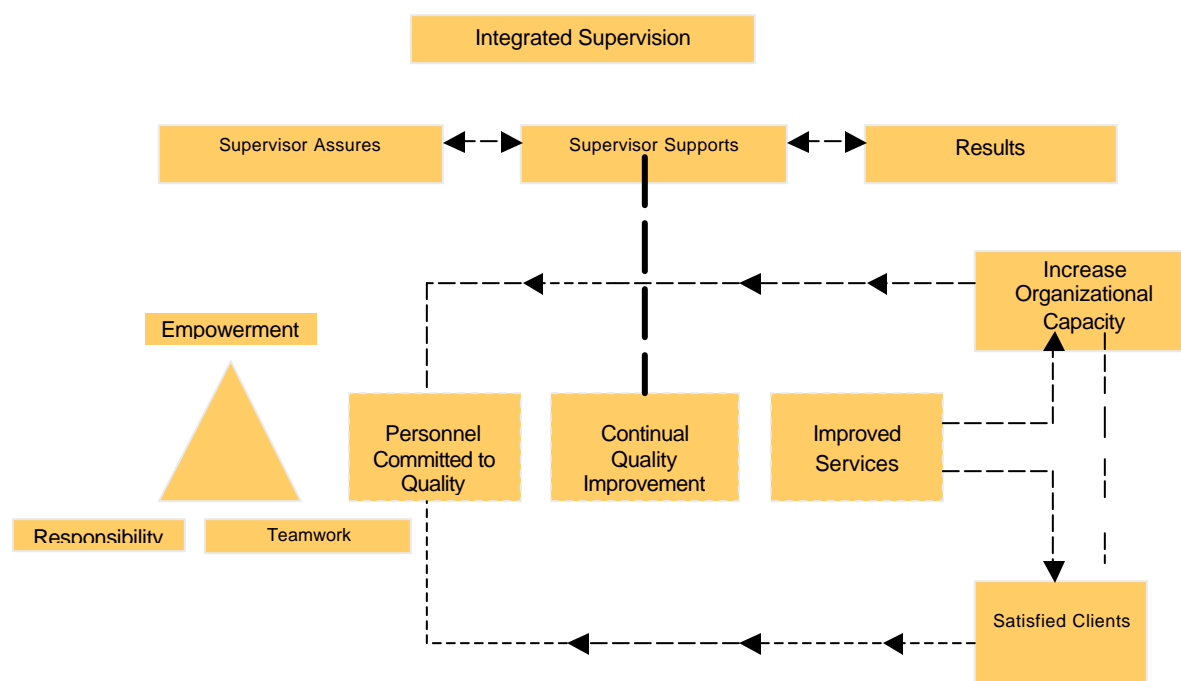
1. Three guides were designed to interview El Alto/Montero managers, supervisors, and all team members. A trial implementation period enabled CSRA to make adjustments to the guides and to set up modified guidelines that orient the user and focus on the most important objectives.
2. Various documents were reviewed which relate to both the theoretical and methodological framework of supervision systems. Various studies and their results within different countries greatly assisted in the design of the system. The texts that were most useful were: “Organizational Management, Module 2” from Pathfinder International, and “Making Supervision Supportive and Sustainable” from MAQ-USAID. Engender Health, Management Sciences for Health (MSH) website, JHPIEGO, and the Set of Management Tools from MSH also proved to be of great assistance.
3. Development of an integrated system of supervision that relates to CSRA’s ‘Policies on Improving Performance’ now forms part of the institution’s System of Management of Human Resources. Supervision is conceptualized in this framework as an element in the management of motivating staff, as is shown in Box No. 1 of the annex.

In this context, *integrated supervision* means focusing on the promotion of continual improvement in the quality of services provided to clients through the strengthening of all levels of health service provision.

The supervision system’s main objective will assure the security and satisfaction of the program’s clients and to promote the professional development of the project staff and volunteers.

The supervision system will be based on the following: Teamwork: understanding that the team and each member have the ability and the responsibility to make programmatic decisions; Empowerment: the development of institutional capacity in order to facilitate personal and professional growth; and Responsibility: the need to establish and define clear lines of authority.

The Program of Continual Quality Improvement will soon be developed and will complement the institution’s supervision system, as is shown in the diagram below.



4. In addition to a document review and an analysis of the results of the diagnostic instruments, CSRA defined the elements that would make up the supervisory system and incorporated them into a table that the program staff find coherent and manageable.

The table below describes the system's designated assignments, as well as the elements yet to be defined:

**Table 4: Elements of Supervision System**

Elements	What have we done?	What do we need to do?	Who will do it?	When?
Systems Diagnosis	Diagnostic in Ancoraimes	Diagnostic in El Alto Diagnostic in Montero	Directors	December 2003
Instruments for the Diagnostic	Designed	Application in Montero and El Alto	Directors	December 2003
Tabulation and Analysis of the results of the diagnostic	Ancoraimes	Carry out in Montero and E Alto	Directors	December 2003
Presentation of diagnostic results	CI December CAI Dec., Jan. Ancoraimes	Presentation	Directors	January 2004

**CURAMERICAS FIRST YEAR CHILD SURVIVAL ANNUAL REPORT--BOLIVIA**

<b>Elements</b>	<b>What have we done?</b>	<b>What do we need to do?</b>	<b>Who will do it?</b>	<b>When?</b>
Define Indicators for Results of Projects and Programs	23 Indicators CSXVIII -Indicators for Project Procosi	-Prioritize indicators -Incorporate other projects and programs.	Directors, Project and Program Managers	Through Nov 2003.
Define Chain of Authority	Organizational Charts and Manuals with job function descriptions.	Revise organizational charts and manuals with complete job functions.	Directors, Project and Program Managers, Human Resources	Through Nov 2003
Define Levels of Supervision (teams)	Yet to be fully defined.	Define levels of supervision	Directors, Project and Program Managers,	Through Nov.2003
Define Objectives of Supervision by Level	To be defined	To be defined	Dir, Project and Program Managers	From the 15 to 17 Dec. 2003
Define Roles, Functions and Frequent Tasks	Developed for IMCI	Adjust and Complete	Dir, Project and Program Managers	From the 15 to 17 Dec. 2003
Define Types of Supervision (Technical, Administrative, Interpersonal)	Tech. Supervisor  Review Relevant Documentation	Define how to work with the different types of supervision.		From the 18 to 19 Dec. 2003
Define Supervision Mechanisms (Autosupervision, Paired Supervision, Internal Supervision, External Supervision)	Internal Supervision, IMCI, Ancoraimes	Define other mechanisms	Dir, Project and Program Managers	Dec. 2003
Define Process of Supervision	IMCI, Ancoraimes, Review Relevant Documentation	Define process of institutional supervision	ME	Dec. 2003
Define and articulate supervision within the Improving Quality Program.	To be defined	Define	ME	Dec 2003
Define and articulate supervision in administrative team.	To be defined	Define	ME, Dir, Project and Program Managers, admin.. and Finance Managers.	From the 22 to 23 of Dec. 2003

**CURAMERICAS FIRST YEAR CHILD SURVIVAL ANNUAL REPORT--BOLIVIA**

<b>Elements</b>	<b>What have we done?</b>	<b>What do we need to do?</b>	<b>Who will do it?</b>	<b>When?</b>
Define and articulate supervision within the monitoring and evaluation and the planning process.	To be defined	Define	ME, Dir, Project and Program Mangers	From the 22 to 23 Dec. 2003
Design of Instruments and Guide to Supervision	Ancoraimes, IMCI	Revise and Complete	ME, Dir, Project and Program Mangers	January
Validate Instruments	IMCI	Do	ME, Dir, Project and Program Mangers	January
Final Version of Instruments	IMCI	Implement	ME	January 2004
Six Month Supervision Plan	To be defined	Make Plan	Directors, Project and Program Managers	January 2004
Information Systems	IMCI	Prepare System	Technical team	January 2004
Training at Different Levels	IMCI	March to Nov.	Directors	2004
Contents, Technical, Duration, Frequency	Manuals, Contents, Review Relevant Documents	Design and Adapt	MEF	February to Nov. 2004
Profile Supervisors, Select	Review Documents	Define	MEF, Directors, Program Mangers, Managers of RRHH	From the 22 to 23 Dec. 2003

The supervision system design will be complete by January 2004. Its implementation will begin in February 2004.

**BOX No. 1.**  
**THEORETICAL FRAMEWORK FOR MOTIVATING THE TEAM**

<p>MOTIVATING OR GROWTH FACTORS</p> <p>↓</p>	<p>-CHANCES TO TAKE ON NEW TYPES OF TASKS</p> <p>-POSSIBILITY OF USING OWN INITIATIVE WITHOUT TIGHT SUPERVISION</p>	<p>HYGIENE OR 'SATISFACTORS'</p> <p>↓</p>	<p>-ORGANIZACIÓN</p> <p>-ADMINISTRATIVE POLICIES</p> <p>-SUPERVISION</p>
<p>FEELING OF PERSONAL ACCOMPLISHMENT</p>	<p>-CHALLENGES</p> <p>-RECOGNITION OF JOBS WELL DONE</p> <p>-OPPORTUNITIES TO ASSUME MORE RESPONSIBILITY</p>	<p>MAINTAIN EMPLOYER-EMPLOYEE RELATIONSHIP</p>	<p>-WORKING CONDITIONS</p> <p>-INTERPERSONAL RELATIONS</p> <p>-SALARY</p>

**ANNEX B: Clarification to Responses from Curamericas' Detailed Implementation Plan  
USAID Child Survival and Health Grants Mini-University, June 2, 2003**

1. *Curamericas should include baseline data and targets for each of the two project sites.*

Baseline and targets for Montero and El Alto (Senkata) have now been included in the table on page 12 and in the objectives and indicator tables in this document.

2. *Curamericas/CSRA will provide a plan for supervision to USAID by October 31, 2003.*

The supervisory system currently in place is described on page 28 in the supervision section of this document. This describes the relationship between Curamericas HQ and CSRA in Bolivia, the reporting structure, and current supervision in the field. The Bolivia CSRA HQ and field level supervisory systems are currently being revised with the support of Curamericas. These revisions will be established by September 2003 and this system will be described in detail in the first annual report to USAID by October 2003.

3. *Curamericas should provide/clarify management plan and organization chart for the two areas.*

A revised organizational chart is included in the annexes of the revised DIP that clarifies the management structure for this project. This is also explained in the supervision section on page 28 of the DIP.

4. *Curamericas should provide a clear strategy (framework) for BCC activities (i.e. Behave Framework).*

Curamericas and CSRA have revised the BCC section on page 29 of the DIP to reflect that the activities target behavior change at different levels (i.e. individual, household, and community). Although not the Behavior Framework recommended to us by our colleagues from CARE, this project will look at doer/non doer analysis through the Barrier Analysis approach. Curamericas' program staff has extensive experience as health educators and has successfully used Barrier Analysis and Trials for Improved Practices to promote behavior change in various countries in Africa and Latin America.

5. *The project should consider adaptation of community AIN-C and clarify the nutrition counseling piece.*

The AIN system uses child weight as a framework and has elements that will be useful in this CS project. But Curamericas and CSRA believe that the use of an AIN-type system would create unnecessary redundancies in combination with our use of IMCI and CBIO methodology. The CBIO methodology provides care reaching the targeted population in their home and community. Curamericas agrees that it is not recommended to change the protocol of growth monitoring sessions and this section has been revised in the appropriate section of this DIP, and this project will follow the Bolivian IMCI guidelines of weighing children under two months of age every 2 weeks.

The Positive Deviance approach for nutrition behavior change has been excluded from the DIP based on recommendations from Juan Carlos Alegre, DIP reviewer, since PD/Hearth is not recommended in sites that have less than a 30% rate of malnutrition. Craig Boynton, Curamericas Program Specialist, and Tom Davis, Curamericas Senior Program Specialist, are in agreement with Juan Carlos Alegre's observation. However, Positive Deviance may be used during the project as a qualitative research/behavior change tool for other child health interventions.

6. *Curamericas should narrow down and/or reword indicators based on review comments/recommendations.*

These have been revised following the recommendations of the reviewers and the KPC indicators. The indicator of “percent of children weighed within the first month of life” has been removed. As mentioned by various DIP reviewers, this indicator did not adequately measure growth faltering and was not designed to do that but was instead included as a measure of quality to ensure that CSRA staff were reaching infants in a timely fashion. This will continue to be collected locally as monitoring indicator for the project staff.

The indicator measuring five doses of Tetanus Toxoid among women 20-24 years of age is maintained. Bolivia’s MOH norm for TT among WRA is five total doses or two TT doses during pregnancy if the woman does not have five prior doses. Curamericas and CSRA follow this norm and, in coordination with local schools, provide TT vaccines during school health education talks to adolescent women starting at 15 years of age. Curamericas and CSRA will be held to achieving the goals established in the indicator for this project.